

Map-811 Non-Credentialed Checklist

NOTICE: Pursuant to 907 KAR 1:672 Section 2 1(c)(1), you must be enrolled as a participating provider prior to being eligible to receive reimbursement. **Enrollment in the program is not a guarantee; therefore, providing services to Kentucky Medicaid members prior to your effective date is at your own financial risk.**

Did you:

- ◆ Complete all questions? Questions not applicable should be completed with “N/A”.
(Applications will be rejected for any questions left blank.)
- ◆ Sign and date signature page (page 10)? ***Only original blue ink signatures are accepted. Copied or stamped signatures are not accepted.***
- ◆ Attach appropriate licenses and/or certifications and all other required documents for requested effective date as well as current?
- ◆ Attach verification documentation for NPI and Taxonomy Code(s) from Fox Systems or NPPES.
- ◆ Attach a Map-347 if individual wants to be linked to group KY Medicaid provider number?
- ◆ Attach copy of Social Security card or signed Notarized Statement if you do not own a FEIN? Attach a W-9 form if you are applying as an individual and you are the sole owner of a FEIN?
- ◆ Attach a W-9 form if you are applying as an entity?
- ◆ Keep a copy of the application for your records?

Not completing these reminders will delay the processing of your application. Please ensure that all reminders above are completed. Other corrections not mentioned above may be requested during the processing of your application.

Please mail the completed application to the following address:

***Kentucky Medicaid
P.O. Box 2110
Frankfort, KY 40602***

Please do not send the application to the Department for Medicaid Services. This will delay the processing of your application.

If you have any questions regarding your enrollment, please call Kentucky Medicaid toll free at **(877)-838-5085**. A provider enrollment specialist will be available to help you between the hours of 8 am and 4:30 pm, EST, Monday through Friday.

MAP-811 Non-Credentialed Provider Application Instructions

**NOTE: Fill out all applicable sections. Indicate Not Applicable (N/A) for questions that do not apply.
Applications will be rejected if any questions are left blank.
Please do not re-format or alter application in any matter.**

Enrollment Block:

- If applying for a Kentucky Medicaid number for the first time, check first block.
- If re-enrolling as a Kentucky Medicaid number, check second block and enter your eight (8) digit provider number in number 1.
- If a change in Federal Tax Identification number (FEIN) or change in ownership has occurred, check third block.
- If applicant has been excluded from Medicare/Medicaid by Federal, State, or court sanction please declare "I am enrolling as a reinstatement", check fourth block.

Section A: Administrative Information

Field #	Description
1	If a Kentucky Medicaid provider number has already been assigned to this entity, please enter provider number.
2	Enter License/Certificate number for the applicant.
3	Enter type of provider. EXAMPLE: physician; hospital; pharmacy; etc. Mark appropriate block for profit or non-profit.
4	Indicate name of individual provider, practice or facility enrolling. Please also mark the appropriate block.
5	Enter the name the provider will be doing business as, if different than field 4, otherwise you may enter N/A. If you are applying for an individual provider number, do not enter your employers name in this field.
6	Enter the type of service that will be provided. EXAMPLE: Acute care; diabetic supplies; etc...
7	Enter the date of your license or the date you wish your enrollment with Medicaid to be effective.
8	Enter your National Provider Identifier (NPI). Please remember to include your FOX verification.
9	Enter your Taxonomy Code(s) associated with your NPI. Attach extra sheet if necessary. Please remember to include your FOX verification.
10	Only ICF/MR providers will enter the beginning and ending dates of their provider certification period; all other providers will enter N/A.
11	State individual Social Security number and date of birth of applicant provider.
12	State corporate Federal Tax Identification Number.
13	Enter the name of the person to sign for a summons in case of a lawsuit (N/A is not acceptable).
14	Telephone number of person named in number 13.
15	If you have held any Kentucky Medicaid group/facility numbers in the past three years, list them here. If not, please indicate with N/A.
16	Physical address of applicant.
17	Physical county of applicant.
18	Physical city of applicant.
19	Physical state of applicant.
20	Physical zip code of applicant.
21	Telephone number of applicant.
22	Contact name and telephone number.
23	Fax number of applicant.
24	Billing location telephone number.
25	Mailing address (where provider receives correspondence such as letters, newsletters, etc.)
26	Email Address
27	Pay-to-address (where providers will receive payment from Medicaid)

- 28 If you are an individual, please list individual Medicare number; if you are an entity, please list entity Medicare numbers. If your Medicare number is pending, you must notify Kentucky Medicaid at the address below in writing when you receive your Medicare number.

Kentucky Medicaid
P.O. Box 2110
Frankfort, KY 40602

- 29 Enter your Unique Provider ID Number.
30 Enter the Drug Enforcement Agency Number (DEA#).
31 Enter effective date of DEA number.
32 Check block if Clinical Laboratory Improvement Agreement (CLIA) is attached.
33 Check this block if copies of specialty licenses are attached.
34 Please enter the supervising physician's name and KY Medicaid provider number.
35 Please complete bed breakdown of facility.

NOTE: Chemical Dependency beds are not covered under the hospital provider type.

- 36 If facility has had a change in beds within the last 2 years, indicate the current bed count and the previous bed count and the date the change occurred.
37 Enter the facility administrator's name with telephone and fax number.
38 Enter Assistant Administrator's name and telephone number.
39 Enter Controller with telephone number.
40 Enter Accountant with telephone number.
41 Enter Fiscal Year End (FYE).
42 This item is voluntary and used for statistical purposes only.

Section B: Disclosure of Ownership and Control Interest
Field # Description

- 1 List all current Kentucky Medicaid provider numbers.
2 If there has been a change of Federal Tax Identification number, please list previous Medicaid provider numbers and effective dates for each.
3 Describe relationship or similarities between the provider disclosing information on this form and items "A" through "C".
4 Do you plan to have a change in ownership, management company or control within the next year? If so, when?
5 Do you anticipate filing bankruptcy? If so, when?
6 State Federal Tax Identification Number if there is an affiliation with a chain along with name, address, city, state and zip code.
7 List name, address, SSN/FEIN of each person or organization having direct or indirect ownership or control interest in the disclosing entity. If owned by a corporation, attach sheet with officers and board members names and social security numbers. If you are applying as an individual and do not own a FEIN, please enter your name and information.

NOTE: Do not send the list of board directors unless they own 5% or more.

Indirect Ownership Interest-means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Ownership interest- means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest- means a person or corporation that:

- Has an ownership interest totaling 5% or more in a disclosing entity;
- Has an indirect ownership interest equal to 5% or more in a disclosing entity;
- Has a combination of direct and indirect ownership interests equal to 5% or more in a disclosing entity;
- Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5% of the value of the property or assets of the disclosing entity;
- Is an officer or director of a disclosing entity that is organized as a corporation; or,
- Is a partner in a disclosing entity that is organized as a partnership

- 8 List name, address and SSN/FEIN of each person with an ownership or control interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more.

Subcontractor- means an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients, OR an individual, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or lease of real property) to obtain space, supplies, equipment or services provided under the Medicaid agreement.

- 9 If applicant is related to persons listed in number 8, please list relationship.

- 10 List name of managing company, if not applicable enter N/A.

- 11 List names of the disclosing entities in which persons have ownership of other Medicare/Medicaid facilities.

Other Disclosing Entity- means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Act. This includes:

- Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII).
- Any Medicare intermediary or carrier.
- Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX or the Act.

- 12 If entity engages with subcontractors such as physical therapist, pharmacies, etc. which exceeds the lesser of \$25,000 or 5% of applicant's operating expense, please list subcontractor's name and address.

Significant Business Transaction- means any business transaction or series of transactions that, during any one fiscal year, exceeds the lesser of \$25,000 or 5% of applicant's operating expense.

- 13 List name, Social Security Number, address of any provider who is authorized to prescribe drugs, medicine, devices, or equipment.

- 14 List anyone in number 7 who has been convicted of a criminal offense related to the involvement of such persons or organizations in any problem established under Title 19 (Medicaid) or Title 20 (Social Services Block Grants) of the Social Security Act or any criminal offense in this state or any other state. Please also indicate any KY Medicaid provider number(s) associated with individual or organization

- 15 List any agent and/or managing employee who has been convicted of a criminal offense related to any program established under Title XVIII, XIX or XX of the Social Security Act or any criminal offense in this state or any other state. Please also indicate any KY Medicaid provider number(s) associated with individual or organization

Agent- means any person who has been delegated the authority to obligate or act on behalf of a provider.

Managing Employee- means a general manager, business manager, administrator, director or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

- 16 For any current or previous Medicaid provider, please list any changes in administrator; director of nursing; medical director.
- 17 Please indicate where you would like monies paid to you from Medicaid reported to for 1099 purposes. *Example: If you are an individual completing this question, please input your Social Security Number unless you are a sole proprietor. An individual can bill under his/her individual provider number even if he/she is working in a group setting.* If you are applying as an individual and do not own a FEIN, but you want your monies reported to the FEIN of the entity, you must complete a Map-347 (Statement of Authorization of Payment) so your individual number can be linked to the group KY Medicaid provider number.
- 18 Please indicate the address where you want your Medicaid 1099 mailed.
- 19 Enter telephone number and extension of where you want Medicaid 1099 mailed.
- 20 Enter the contact name for the Medicaid 1099.
- 21 Please attach a listing of all professionals currently employed in your group. Include provider name, begin date (if known) and the individual's Medicaid provider number.
- 22 If you are applying as an individual and you are a sole owner of a FEIN and want your monies reported to your FEIN, please attach a W-9, "Request for Taxpayer Identification Number and Certification". Please attach a copy of your Social Security card or notarized statement signed by you attesting to your SSN if you are not a sole owner of a FEIN. If you are applying as an entity, please attach a W-9.

Section C: Tax Structure

Field #	Description
1	<p>Check block, which pertains to applicant's tax structure.</p> <ul style="list-style-type: none">• If "B" is marked, please complete number 2 with name, address, city, state, zip code, and telephone number.• If "C" is marked, please complete number 3 with name, address, city, state, zip code and FEIN/SSN.• If "E" is marked, please attach a list of Officer and Board Members.• If "F" is marked, please attach list of Board Members.• If "G" is marked, please attach list of Board Members.• If "H" is marked, please attach list of Limited Liability members.

Page 10 (Signature Page)

Provider Signature: Enter original blue ink signature from the director, administrator, individual provider, owner, or authorized personnel. **(Copied or stamped signatures are not accepted.)**

Name: Printed name of provider

Title: Title of person signing. EXAMPLE: administrator; doctor; etc...

Date: Enter the date the agreement was signed

Witnessed By: Enter original blue ink signature of witness **(Copied or stamped signatures are not accepted.)**

Health Care Partnership Signature:

To be completed by Managed Care representative only

Regional Transportation Broker Signature:

This field is to be completed by the transportation broker. All taxi providers, non-ambulatory specialty carriers, and bus-co-ops must have this field completed. If field is incomplete the application will be rejected for participation with the Kentucky Medicaid program.

Department for Medicaid Services Signature:

To be completed by Department for Medicaid Services

I am Enrolling as a:

- ☐ New Provider
- ☐ Re-applicant
- ☐ Change of Ownership/FEIN
- ☐ Re-Instatement

**COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES
And/Or
KENTUCKY HEALTH CARE PARTNERSHIP**

PROVIDER APPLICATION

For Kentucky Medicaid Use Only

ATN# _____

ATN# _____

ATN# _____

Identifier: _____

Provider Type: _____

Reviewer's Initials: _____

SECTION A: ADMINISTRATIVE INFORMATION

1. _____

Kentucky Medicaid Provider Number

(Complete if you have a current or previous Kentucky
medicaid provider number; otherwise, enter N/A or Pending.)

2. License/Certification # _____

3. Type of Provider _____ ☐ For Profit ☐ NonProfit

4. _____

Provider Name -OR- Entity Name Enrolling

☐ Applying as Individual ☐ Applying as Entity/Group

5. _____

Doing Business As (DBA)

(Does not apply to an individual who is not a sole owner of a FEIN).

6. _____

Type of Service

7. _____

Date Provider Requests Effective Enrollment

8. _____

NPI (National Provider Identifier)

9. _____

Taxonomy Code(s) (Attach extra sheet if necessary.)

10. ICF/MR/DD Only:

If the named Provider in this agreement is an ICF/MR/DD this agreement shall begin on _____, 20____, with conditional termination on _____, 20____, unless the facility is re-certified in accordance with applicable regulations and policies.

11. SSN: [][][][][][][][][][][][][][][][][] **and** DOB: [][][][][][][][][][][][][][][][][]

Month Day Year

12. FEIN (if applicable): [][][][][][][][][][][][][][][][][] (Does not apply to an individual who is not the sole owner of a FEIN)

13. _____

Agent of Service in Case of Summons (N/A not acceptable.)

14. (_____)

Telephone # of Agent of Service Ext. #

15. List any Kentucky Medicaid **group / facility** numbers you have held in the past three years.

[][][][][][][][][][][][][][][][][] [][][][][][][][][][][][][][][][][] [][][][][][][][][][][][][][][][][]

State primary physical business location in 16 through 20. If you have more than one physical location, attach a copy of items 16-23, listing additional locations.

16. _____

Address

17. _____

County

18. _____

City

19. [][][][][][] 20. _____ - _____

State (2-digit)

Zip

21. (_____)

Telephone #

Ext.

22. _____

Contact Name (First and Last Name)

23. (_____)

Fax #

24. (_____)

Billing Location Telephone #

Ext.

State MAILING Address *(if different from physical address)*

25. _____
 Address _____ City _____

[][] _____ - _____
 State Zip

26. **Email Address (optional)** _____ **Note:** Your email address will not be given to any outside party for any reason. DMS may use provider email addresses to send provider letters/notices.

State PAY-TO Address *(if different from physical address)* .

27. _____
 Address _____ City _____

[][] _____ - _____
 State Zip

28. **Please list all Medicare Provider Numbers. (Attach extra sheet if necessary.)**

(a) _____ (b) _____ (c) _____

29. _____ 30. _____ 31. _____
 UPIN # DEA # DEA # Effective Date

32. **Attach a copy of CLIA**

☐ I have attached a copy.

33. **Attach a copy of specialty certification.**

☐ I have attached a copy.

34. **If you are applying as a Physician Assistant, please indicate supervising physician name & KY Medicaid provider number. Attach extra page is necessary. Please attach a Map-612 for each supervising physician.**

Name _____ KY Medicaid Provider Number _____

35. **Bed Breakdown**

[][][] Acute [][][] ICU [][][] Surgical ICU [][][] Burn ICU
 [][][] TCU [][][] Nursery [][][] Neonatal ICU [][][] CCU
 [][][] Hosp. Swing [][][] Rehab. Hosp. [][][] Psych. Hosp. [][][] PRTF

[][][] ICF/MR/DD [][][] Ventilator Unit [][][] Brain Injury Unit

[][][] NF/Medicaid [][][] NF (Medicare/Medicaid)

[][][] Other /specify: _____

36. **If your bed capacity has increased by 10% OR by 10 beds, whichever is greater, within the last two (2) years, give current bed and prior bed counts and the date change occurred:**

[][][][] [][][][] _____
 Current Bed Count Prior Bed Count Date of Change

37. _____ (_____) _____
Administrator Phone Number Ext.

Fax # _____
38. _____ (_____) _____
Assistant Administrator Phone Number Ext.

39. _____ (_____) _____
Controller Phone Number Ext.

40. _____ (_____) _____
Accountant or CPA Phone Number Ext.

41. **Fiscal Year Ends Date (FYE)** _____.
42. **For statistical purposes only. Not required.**
- Race:** _____ **Sex (circle one):** **M** **F**

SECTION B: DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST

ITEMS 1-15 BELOW ARE REQUIRED BY FEDERAL AND STATE LAW AND REGULATION (42 CFR 455.104 AND KRS CHAPTER 205, AS AMENDED). YOU WILL RECEIVE THIS SECTION ANNUALLY TO UPDATE AND RETURN TO DMS.

Note: See page 8 for definitions according to 42 CFR 455.101 and 455.104 and KRS Chapter 205, as amended, of underlined terms in Section B.

1. List all current Kentucky Medicaid provider numbers:

2. If there has been a change in ownership, change of tax ID number (FEIN), or change in Kentucky Provider Number for a previously enrolled Kentucky Medicaid provider, please state previous provider number(s) and their effective date(s):

Previous Medicaid Prov. # Mo. Day Yr. to Mo. Day Yr.

Previous Medicaid Prov. # Mo. Day Yr. to Mo. Day Yr.

3. If you completed #2, describe the relationship between the provider disclosing information on this form, and the following: (a) previous Medicaid owner (b) corporate boards of disclosing provider and previous Medicaid owner; i.e. board members and ownership or control interest (c) disenrollment circumstances. Attach extra page if necessary.

4. If you anticipate any change of ownership, management company or control within the year, state anticipated date of change and nature of the change. Date: _____ Change: _____

5. If you anticipate filing for bankruptcy within the year, state anticipated date of filing. _____

6. If this facility is a subsidiary of a parent corporation, state corporate FEIN #: _____

Name: _____

Box or Address: _____

City: _____

State: Zip: _____ - _____

7. List name, date of birth, SSN#/FEIN#, and address of each person or organization that owns 5% or more direct or indirect ownership or controlling interest in the applicant provider. If owned by a corporation, please list names and social security numbers of Officers and Board Members of that corporation. (Attach extra page if necessary.) If you are applying as an individual, please list *your* information. (N/A not acceptable.)

☐ Check here if no one has 5% or more direct or indirect ownership, and skip to item #8.

NAME (a): _____ DOB: _____

Box or Address: _____ SSN: _____

City: _____ -and/or- FEIN: _____

State: Zip: _____ - _____

NAME (b): _____ DOB: _____
Box or Address: _____ SSN: _____
City: _____ -and/or-
FEIN: _____
State:[____][____] Zip: _____ - _____

8. List name, address, SSN#, FEIN# of each person with an ownership or control interest in any subcontractor in which the provider applicant has direct or indirect ownership of 5% or more. Attach extra page if necessary.

NAME (a): _____ SSN: _____
Box or Address: _____ -and/or-
FEIN: _____
City: _____
State:[____][____] Zip: _____ - _____

NAME (b): _____ SSN: _____
Box or Address: _____ -and/or-
FEIN: _____
City: _____
State:[____][____] Zip: _____ - _____

9. If any individuals listed in item #8 (above) are related to each other as spouse, parent, child, or sibling (including step or adoptive relationships), provide the following information: (Attach extra page if necessary.)

Name: _____	Name: _____
Relationship: _____	Relationship: _____
SSN: _____	SSN: _____
-and/or- FEIN: _____	-and/or- FEIN: _____

10. If this facility employs a management company, please provide following information:

Name: _____
Box or Address: _____
City: _____
State:[____][____] Zip: _____ - _____

11. List the names of any other disclosing entity in which person(s) listed on this application have ownership of other Medicare/Medicaid facilities.

NAME (a): _____ Provider #: _____
Box or Address: _____
City: _____
State:[____][____] Zip: _____ - _____

NAME (b): _____ Provider #: _____

Box or Address: _____

City: _____

State:[____][____] Zip: _____ - _____

12. List the names and addresses of all other Kentucky Medicaid providers with which your health service and/or facility engages in a significant business transaction and/or a series of transactions that during any one (1) fiscal year exceed the lesser of \$25,000 or 5% of your total operating expense. (Attach extra page if necessary.)

NAME (a): _____

Box or Address: _____

City: _____

State:[____][____] Zip: _____ - _____

NAME (b): _____

Box or Address: _____

City: _____

State:[____][____] Zip: _____ - _____

13. List the name, SSN, and address of any immediate family member who is authorized under Kentucky Law or any other states' professional boards to prescribe drugs, medicine, medical devices, or medical equipment in accordance with KRS 205.8477.

NAME(a): _____ Credential (M.D., etc.) _____

Box or Address: _____ DOB: _____

City: _____ SSN: _____

State: [____][____] Zip: _____ - _____

NAME(b): _____ Credential (M.D., etc.): _____

Box or Address: _____ DOB: _____

City: _____ SSN: _____

State:[____][____] Zip: _____ - _____

14. List the name of any individuals or organizations having direct or indirect ownership or controlling interest of 5% or more, who have been convicted of a criminal offense related to the involvement of such persons, or organizations in any program established under Title XVIII (Medicare), or Title XIX (Medicaid), or Title XX (Social Services Block Grants) of the Social Security Act or any criminal offense in this state or any other state, since the inception of those programs. (Attach extra page if necessary.) .) If individual or organization is associated with a KY Medicaid provider number(s), please indicate below. (Attach extra page if necessary.)

NAME (a)/KY Medicaid Provider Number(s)

NAME (b)/KY Medicaid Provider Numbers(s)

15. List the name of any agent and/or managing employee of the disclosing entity who has been convicted of a criminal offense related to the involvement in any program established under Title XVIII, XIX, or XX, or XXI of the Social Security Act or any criminal offense in this state or any other state. (Attach extra page if necessary.) .) If individual or organization is associated with a KY Medicaid provider number(s), please indicate below. (Attach extra page if necessary.)

NAME (a)/KY Medicaid Provider Number(s)

NAME (b)/KY Medicaid Provider Number(s)

- 16. For any previously enrolled Medicaid provider, please list any change in:**

Administrator: _____

Director of Nursing (DON): _____

Medical Director: _____

17. DMS will report all monies paid to you to the IRS. Please indicate which number you use for tax reporting:
(If you are enrolling as an individual and do **not** own a FEIN, please complete SSN field only.)

Report DMS payments to my FEIN: [][][][][][][][]

Report DMS payments to my SSN: [][][][][][][][]

- 18. Where do you want your Medicaid 1099 (annual earnings form) mailed?**

Name: _____

Box or Address:

City: _____

State: [] Zip: -

19. ()
Telephone # Ext.
20. Contact Person (first and last name) _____

21. If you are a Kentucky Medicaid Group (more than one professional of the same provider type) please attach a listing of all professionals currently employed in your group. Include the provider name, begin date with the group and the individuals Kentucky Medicaid provider number.

22. If you are applying as an individual and you are a sole owner of a FEIN and want your monies reported to your FEIN, please attach a W-9, "Request for Taxpayer Identification Number and Certification". Please attach a copy of your Social Security card or notarized statement signed by you attesting to your SSN if you are not a sole owner of a FEIN. If you are applying as an entity, please attach a W9.

455.104 Definitions:

1. **Indirect Ownership Interest** means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.
2. **Other Disclosing Entity** Means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:
 - (a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);
 - (b) Any Medicare intermediary or carrier; and
 - (c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishings of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.
3. **Person with an Ownership or Control Interest** means a person or corporation that:
 - (a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
 - (b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
 - (c) Has a combination of direct or indirect ownership interests equal to 5 percent or more in a disclosing entity;
 - (d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
 - (e) Is an officer or director of a disclosing entity that is organized as a corporation; or
 - (f) Is a partner in a disclosing entity that is organized as a partnership
4. **Subcontractor** means:
 - (a) An individual, agency, organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
 - (b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or lease of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

SECTION C: TAX STRUCTURE

1. Provider Tax Structure of Applicant: Please check only one (1).

- ☐ (A) Individual
- ☐ (B) Sole Proprietor
- ☐ (C) Partnership
- ☐ (D) Estate/Trust
- ☐ (E) Corporation (**please attach a list of Officers' and Board Members' names or list below**).
- ☐ (F) Public Service Corporation (**please attach a list of Officers' and Board Members' names or list below**).
- ☐ (G) Government/Non-Profit (**please attach a list of Officers' and Board Members' names or list below**).
- ☐ (H) Limited Liability Company (**please attach a list of Officers' and Board Members' names or list below**).

2. If tax structure is (B) Sole Proprietor, give name, d.b.a. (if applicable), address, and telephone number of owner:

Name (and d.b.a. if applicable)

Address

City

[__][__] _____ - _____ (_____) _____
State (2-digit) Zip Telephone # Ext.

3. If tax structure is "C" Partnership, list name, address, and the social security numbers of partners:

Name	Address	SSN
_____	_____	_____
_____	_____	_____

Officers' and Board Members' Names:

WHOEVER KNOWINGLY OR WILLFULLY MAKES, OR CAUSES TO BE MADE, A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT SHALL BE SUBJECT TO PROSECUTION UNDER APPLICABLE FEDERAL OR STATE LAWS. (42USC 1320A-7B, CRIMINAL PENALTIES FOR ACTS INVOLVING FEDERAL HEALTH CARE PROGRAMS IS PRINTED ON PAGE 13) FAILURE TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED SHALL RESULT IN A DENIAL OF A REQUEST TO PARTICIPATE IN OR TERMINATION OF THE CURRENT AGREEMENT WITH THE STATE AGENCY, AS REQUIRED BY 42 CFR 455.104 AND KRS CHAPTER 205 AS AMENDED.

Provider Authorized Signature: I certify, under penalty of law, that the information given in this form is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Program and/or for prosecution for Medicaid fraud. I certify that I have read and understand the "Medicaid Rules, Regulation, Policy and 42USC 1320a-7b" (pp. 11-13) to the best of my ability. I agree to abide by the Medicaid Program terms and conditions listed in this document, and I hold a license/certification to provide service corresponding to the information above and for which this agreement applies. I hereby authorize the Cabinet for Health and Family Services, the Kentucky Health Care Partnership to make all necessary verification concerning me and/or my medical practice/facility, and further authorize each educational institute, medical/license board or organization to provide all information that may be needed in connection with my application for participation in the Kentucky Medicaid Program. I further certify that, if I keep medical records on an electronic database, those records are confidential and patient privacy is protected (KRS 205.510).

Provider Signature:
(BLUE INK ONLY)

Health Care Partnership Signature:
(BLUE INK ONLY)

Name (please print): _____

Name (please print): _____

Title: _____

Title: _____

Date: _____

Date: _____

Witnessed by (Signature): _____

Regional Transportation Broker Signature:

Department for Medicaid Services:

Broker Name: _____

Name: _____

Broker Signature: _____
(BLUE INK ONLY)

Title: _____

Approval Date: _____

Date: _____

NOTE: Please ensure that no questions were left blank before submitting application.

PLEASE MAKE A COPY OF COMPLETED PAGES FOR YOUR RECORDS. YOU WILL RECEIVE A DMS-SIGNED COPY OF THIS PAGE ALONG WITH NOTIFICATION OF YOUR KENTUCKY MEDICAID PROVIDER NUMBER.

MEDICAID RULES, REGULATION, POLICY AND 42USC 1320a-7b

1. Scope of Agreement:

This provider agreement sets forth the rights, responsibilities, terms and conditions governing the provider's participation in the Kentucky Medicaid Program, KenPAC, KCHIP and/or Kentucky Health Care Partnership and supplements those terms and conditions imposed by these four (4) programs.

2. Medical Services to be Provided:

The provider agrees to provide covered services to Medicaid, KenPAC and KCHIP recipients in accordance with all applicable federal and state laws, regulations, policies and procedures relating to the provision of medical services according to Title XIX, Title VI, the approved Waivers for Kentucky and, for those providers participating in the Partnership, all applicable provisions of the pertinent contract for managed care and policies and procedures duly adopted by the governing board of the Partnership applicable to provider and recipients of Title XIX services.

3. Assurances:

The Provider:

- (1) Agrees to maintain such records, including electronic storage media, as are necessary to document the extent of services furnished to KCHIP and Title XIX recipients for a minimum of five (5) years or as required by state and federal laws, and for such additional time as may be necessary in the event of an audit exception, quality of care issue, or other dispute and to furnish the state or federal agencies with any information requested regarding payments claimed for furnishing services.
- (2) Agrees to permit representatives of the state and federal government, and, for those providers participating in the Partnership, staff of the Kentucky Health Care Partnership to have the unrestricted right to examine, inspect, copy and audit all records pertaining to the provision of services furnished to KCHIP and Title XIX recipients. Such examinations, inspections, copying and audits may be made without prior notice to the Provider. This right shall include the ability to interview facility staff during the course of any inspection, review, investigation or audit.
- (3) Agrees to comply with the Civil Rights requirements set forth in 45 CFR Parts 80, 84, and 90 and the Americans with Disabilities Act (ADA), 42 USC 12101. Payments shall not be made to providers who discriminate on the basis of race, color, national origin, sex, disability, religion, age or marital status in the provision of services.
- (4) Agrees to cooperate with applicable public health agencies to coordinate appropriate medical care for KCHIP and Title XIX recipients in order to ensure quality of care and avoid the provision of duplicate or unnecessary medical services.
- (5) Assures awareness of the provisions of 42 USC 1320a-7b reproduced on page 13 of this agreement and of the provisions of KRS 205.8451 to KRS 205.8483 relating to Medicaid Program Fraud and Abuse, and applicable Kentucky Administrative Regulations as specified in Title 907 relating to the Kentucky Health Care Partnerships and Provider Agreements.
- (6) Agrees to inform the Cabinet for Health Services, Department for Medicaid Services or the appropriate Partnership;
 - A. within thirty-five (35) days of any change in the following:
 1. name;
 2. ownership;
 3. address; and,
 - B. within five (5) days of information concerning the following:
 1. change in licensure/certification;
 2. regulation status;
 3. disciplinary action by the appropriate professional association; and,
 4. criminal charges
- (7) Agrees to the following:
 - A. To assume responsibility for appropriate, accurate, and timely submission of claims and encounter data whether submitted directly by the provider or by an agent;
 - B. To use EMC submittal procedures and record layouts as defined by the Cabinet if submitting electronic claims;
 - C. That the provider's signature on this agreement constitutes compliance with the following: the transmitted information is true, accurate and complete and any subsequent correction which alters the information contained therein will be transmitted promptly;
 - D. Payment and satisfaction of claims will be from federal and state funds and that any false claims, statements, or documents or concealment of falsification of a material fact, may be prosecuted under applicable federal and state law.
- (8) Agrees to participate in the quality assurance programs of the partnership and the Department for Medicaid Services and understands that the data will be used for analysis of medical services provided to assure quality of care according to professional standards.
- (9) A contract for the sale or change of ownership participating in the Medicaid Program shall specify whether the buyer or seller is responsible for the amounts owed to the department by the provider, regardless of whether the amounts have been identified at the time of sale. In the absence of such specification in the contract for the sale or change of ownership, the owners or the partners at the time the department paid the erroneous payments have the responsibility for liabilities arising from those payments, regardless of when identified.
- (10) Agrees to notify the Department for Medicaid Services and/or the Partnership in writing of having filed for protection from creditors under the Bankruptcy code within five (5) days of having filed a petition with the court. Notification shall include the number assigned the case by the court, and the identity of the court in which the petition was filed.
- (11) Agrees to return any overpayment made by the Department for Medicaid Services and/or Partnership resulting from agency error in calculation of amount or review of submitted claims.

4. ITEM # 4 APPLIES ONLY TO LONG TERM CARE FACILITIES (NF, ICF/MR or Mental Hospital), AND HOME COMMUNITY BASED Waiver SERVICES (HCB, SCL, Model Waiver II, Acquired Brain Injury, etc.)

As a result of the Medicare Catastrophic Coverage Act of 1988, each facility providing long term care services agrees to advise all new admissions of resource assessments to assist with financial planning performed by the Department for Community Based Services through a contractual arrangement with the Department for Medicaid Services. This requirement is a Condition of Participation in the Kentucky Medicaid Program, in accordance with 907 KAR 1:672 and is effective with new admissions on and after September 30, 1989.

Each nursing facility agrees to comply with the preadmission screening and resident review requirement specified in Section 1919 of the Social Security Act, effective with regard to admissions and resident stays occurring on or after January 1, 1989.

5. Payment:

In consideration for the provision of approved Title XIX services rendered to Medicaid recipients and Title XXI services rendered to KCHIP recipients and subject to the availability of federal and state funds:

- (1) The Cabinet for Health Services, Department for Medicaid Services agrees to reimburse the provider according to current applicable federal and state laws, rules and regulations and policies of the Cabinet for Health Services for providers participating as direct Medicaid payment providers. Payment shall be made only upon receipt of appropriate billings and reports as prescribed by the Cabinet for Health and Family Services, Department for Medicaid Services.
- (2) The Partnership agrees to reimburse the provider according to the provisions of the Partnership agreement with the provider. Payments shall be made only upon receipt of appropriate encounter data, claims and reports as prescribed by the Partnership governing board.
- (3) In accordance with 42 CFR 447.15, if the department makes payment for a covered service and the provider accepts this payment in accordance with the department's fee structure, the amounts paid shall be considered payment in full; a bill for the same service shall not be tendered to the recipient, and a payment for the same service shall not be tendered to the recipient, and a payment for the same service shall not be accepted from the recipient. A provider may not bill a Medicaid recipient for a bill that was denied due to incorrect billing. A provider may bill a Medicaid recipient under the following conditions:
 - a. Service not covered by Kentucky Medicaid, and member was previously informed of the non-covered service.
 - b. Provider is not enrolled in Kentucky Medicaid.

6. Provider Certification:

- (1) If the provider is required to participate or hold certification under Title XVIII of the Social Security Act to provide Title XIX services, the provider assures such participation or certification is current and active.
- (2) If the Provider is a specialty hospital providing psychiatric services to persons age twenty-one (21) and under, the Provider shall be approved by the Joint Commission on Hospitals or the Council on Accreditation of Services for Families and Children or any other accrediting body with comparable standards that are recognized by the state. In the event that the Provider is a general hospital, the Provider shall be certified for participation under Title XVIII of the Social Security Act or the Joint Commission on the Accreditation of Health Care Organizations.
- (3) Home Care Waiver Services agrees to comply with the conditions for participation established in 907 KAR 1:070. All staff shall meet all training requirements prior to providing services.
- (4) Personal Care Assistance Programs agree to comply with the conditions for participation established in 907 KAR 1:090. All staff shall meet all training requirements prior to providing services.

7. Lobbying Certification:

The provider certifies that to the best of one's knowledge and belief, that during the preceding contract period, if any, and during the term of this agreement:

- (1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influence or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.
- (2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL 'Disclosure Form to Report Lobbying' in accordance with its instructions.
- (3) The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.
- (4) This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into, submission of this certification is a prerequisite for making or entering into this transaction imposed under Section 1352 Title 31. US code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for such failure.

8. Termination

- (1) The Department for Medicaid Services and/or partnership or provider shall have the right to terminate this agreement for any reason with up to thirty (30) days written notice served upon the other party by registered mail with return receipt requested. The Partnership and/or Department for Medicaid Services may terminate this agreement immediately for cause, or in accordance with state or federal laws, upon written notice served upon the Provider by registered mail with return receipt requested.
- (2) If Medicare or Medicaid terminates the provider, the Partnership shall also terminate the provider from participation.
- (3) If there is a change of ownership of nursing facility, the Cabinet for Health and Family Services agrees to automatically assign this agreement to the new owner according to 42 CFR 442.14.
- (4) Failure of a provider to comply with the terms of this agreement may result in the initiation of the following sanctions:
 - Freezing member enrollment with the provider.
 - Withholding all or part of the provider's monthly management fee.
 - Making a referral to the Division of Fraud, Waste, & Abuse/Identification and Prevention in the Office of Inspector General for investigation of potential fraud or quality of care issues.
 - Terminating the provider from the KenPAC program.

The Department will allow the provider two weeks to cure any violation that could result in the sanctioning of the provider. If the provider does not or refuses to cure the violation, the Department will proceed with action to impose sanctions on the provider. If sanctions are applied against the provider, the action will be reported to the appropriate professional boards and/or agencies. One or more of the above sanctions may be initiated simultaneously at the discretion of the Department based on the severity of the contraction violation. The Commissioner makes the determination to initiate sanctions against a provider. The provider will be notified of the initiation of a sanction by certified mail.

42USC Section 1320a-7b. Criminal Penalties for Acts Involving Federal Health Care Programs

- (a) Making or causing to be made false statements or representations
Whoever-
- (1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program (as defined in subsection (f) of this section),
- (2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,
- (3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized.
- (4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,
- (5) presents or causes to be presented a claim for a physician's service for which payment may be made under a Federal health care program and knows that the individual who furnished the service was not a licensed physician, or
- (6) knowingly and willfully disposed of assets (including by any transfer in trust) in order for an individual to become eligible for medical assistance under a State plan under subchapter XIX of this chapter, if disposing of the assets in the imposition of a period of ineligibility for such assistance under section 1396p© of this title, shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which the payment is or may be made under the program, be guilty of a felony and upon conviction thereof fined not more than \$25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than \$10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a Federal health care program is convicted of an offense under the preceding provisions of this subsection, the administrator of such program may at its option (notwithstanding any other provision of such program) limit, restrict, or suspend the eligibility of that individual for such periods (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between the individual and such other person.
- (b) Illegal remunerations
- (1) whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind
- (A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or
- (B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.
- (2) whoever knowingly and willfully offers or pays any remuneration (including kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person-
- (A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or
- (B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.
- (3) Paragraphs (1) and (2) shall not apply to-
- (A) a discount or other reduction in price obtained by a provider of services or other entity under a Federal health care program if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under a Federal health care program;
- (B) any amount paid by an employer (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services;
- (C) any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services reimbursed under a Federal health care program if-
- (i) the person has a written contract, with each such individual or entity, which specifies the amount to be paid the person, which amount may be a fixed amount or a fixed percentage of the value of the purchases made by each such individual or entity under the contract, and
- (ii) in the case of an entity that is a provider of services (as defined in section 1395x(u) of this title), the person discloses (in such form and manner as the Secretary requires) to the entity and, upon request, to the Secretary the amount received from each such vendor with respect to purchases made by or on behalf of the entity;
- (D) a waiver of any coinsurance under part B of subchapter XVIII of this chapter by a Federally qualified health care center with respect to an individual who qualifies for subsidized services under a provision of the Public Health Service Act (42 U.S.C.A. section 201 et seq.);
- (E) any payment practice specified by the Secretary in regulations promulgated pursuant to section 14(a) of the Medicare and Medicaid patient and Program Protection Act of 1987; and
- (F) any remuneration between an organization and an entity providing items or services, or a combination thereof, pursuant to a written agreement between the organization and the individual or entity if the organization is an eligible organization under section 1395mm of this title or if the written agreement, through a risk-sharing arrangement, places the individual or entity at substantial financial risk for the cost or utilization of the items or services, or a combination thereof, which the individual or entity is obligated to provide.
- (c) False statements or representations with respect to condition or operation of institutions
Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution, facility, or entity in order that such institution, facility, or entity may qualify (either upon initial certification or upon rectification) as a hospital, rural primary care hospital, skilled nursing facility, intermediate care facility for the mentally retarded, home health agency, or other entity (including an eligible organization under section 1395mm(b) of this title) for which certification is required under subchapter XVIII of this chapter of a State health care program (as defined in section 1320a-7(h) of this title), or with respect to information required to be provided under section 1320-a-3a of this title, shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.
- (d) Illegal patient admittance and retention practices
Whoever knowingly and willfully-
- (1) charges, for any service provided to a patient under a State plan approved under subchapter XIX of this chapter, money or other consideration at a rate in excess of the rates established by the State, or
- (2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under subchapter XIX of this chapter, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)-
- (A) as a precondition of admitting a patient to a hospital, nursing facility, or intermediate care facility for the mentally retarded, or
- (B) as a requirement for the patient's continued stay in such a facility, when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.
- (e) Violation of assignment terms
Whoever accepts assignments described in section 1395u(b)(3)(B)(ii) of this title or agrees to be a participating physician or supplier under section 1395u9h(1) of this title and knowingly, willfully, and repeatedly violates the term of such assignments or agreement, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$2,000 or imprisoned for not more than six months, or both.
- (f) "Federal health care program" defined
For purposes of this section, the term "Federal health care program" means-
- (1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the health insurance program under chapter 89 of Title 3); or
- (2) any State health care program, as defined in section 1320a-7(h) of this title.

